



ELSEVIER

Available online at [www.sciencedirect.com](http://www.sciencedirect.com)

ScienceDirect

journal homepage: <http://www.elsevier.com/locate/kontakt>

## Original research article

# Mental health problems as one of the factors in the development and persistence of homelessness

Tomáš Habánik \*

University of Ss. Cyril and Methodius, Faculty of Social Sciences, Trnava, Slovak Republic

## ARTICLE INFO

Received: 2017-11-08  
 Received in revised form:  
 2018-01-15  
 Accepted: 2018-03-22  
 Published online: 2018-06-26

## Keywords:

Homelessness  
 Mental health  
 Addiction  
 Homeless people

## ABSTRACT

The study aims to identify the presence of psychiatric disorders (and the different types) among the homeless, while also seeking a correlation between homelessness and mental health problems. The study was conducted as qualitative research at a low-threshold day treatment center in Trenčín between January 1 and October 1, 2017. The research sample consisted of twelve users of low-threshold social services, and through these participants we examined and identified not only the extent of psychiatric disorders present in them, but also the current state of treatment and the interest of the participants in addressing existing mental health problems alongside their relationship to their social environment. The results of the study demonstrated the connection between homelessness and mental health problems, as well as the consequences of the failure to treat psychological problems due to how the homeless act and their behavior toward their social environment, limiting the ability to reintegrate them into society.

© 2018 Jihočeská univerzita v Českých Budějovicích, Zdravotně sociální fakulta.  
 Published by Elsevier Sp. z o. o. All rights reserved.

## Introduction

Society is currently able to tackle social insecurity in many areas of everyday life, whose consequences gives rise to various social risks inherent in conjunction with an adverse social/life situation [1]. In this context, an equally large number of people have no opportunity for adequate housing or have been prevented from receiving access to such housing [2]. As a result, they are forced to use various forms of non-compliant or insecure housing. In extreme cases this leads to living on the street, as they have been unable either to overcome their plight or to cope with it.

Housing loss and the homelessness resulting from this has become extreme [3].

There is a correlation between homelessness as an extreme expression of social exclusion and lack of access to basic human rights [4]. In light of these circumstances, it can be stated that, on a daily basis, homeless people experience exclusion and infringement by society of their basic human rights [5].

Although homelessness is connected primarily with housing loss, it is important to think about the deeper definition of the term *home*. Home has a deeper context, providing a space not only to live in, but also a place that guarantees feelings of safety, security and expressions of

\* **Author for correspondence:** PhDr. Tomáš Habánik, PhD., University of Ss. Cyril and Methodius, Faculty of Social Sciences, Bučianska 4/A, 917 01 Trnava, Slovak Republic; e-mail: [tomas.habanik@ucm.sk](mailto:tomas.habanik@ucm.sk); [thomas.habanik@gmail.com](mailto:thomas.habanik@gmail.com)  
<http://dx.doi.org/10.1016/j.kontakt.2018.03.004>

identity or the development of social interactions with family, friends and acquaintances, thus contributing to an individual's emotional well-being [6]. Housing loss is often accompanied by a lack of social support, substance abuse, an inappropriate and dysfunctional family environment or experience with selected types of institutional care [7]. Homelessness is also usually accompanied by the widespread incidence of physical and mental health complications [8–10]. Here, health can be defined as one of the most important values in human life, from which all other aspects derive [11].

The trigger mechanism of homelessness can thus shape the consequences of psychiatric disorders and diseases in conjunction with the presence of socioeconomic problems. For these reasons specific to homeless people, they lack social support and have no safe haven, namely a home, and this is an indisputable factor affecting their mental health [12].

It is important to pay attention to a number of studies documenting significant cases of psychiatric disorders and mental illness among the homeless, touching upon depression and anxiety, suicide attempts and emotional problems [13]. However, a very substantial percentage of the homeless with mental illnesses are also dependent on alcohol or drugs [14]. A mental illness primarily affects their thinking as well as their moods and emotions, and also significantly affects their ability to establish and maintain relationships [15].

It is extremely difficult to tackle mental illnesses when homeless people have both no opportunity to receive adequate treatment and no space to recover. Homelessness is accompanied by minimal contact with a physician or missing medical files [16]. Two of the reasons many homeless people do not seek medical and specialized assistance can be the fear of getting help or bad experiences from having been rejected by so many doctors. Living rough on the street or in an open area leads to constant stress and danger, with the combination of homelessness and other psychiatric disorders only worsening overall health. Homeless people suffering from psychiatric disorders who are not getting treatment have only a minimal chance to break out of the street environment. In turn, the interconnection between these factors creates a space for other sociopathological phenomena (like prostitution and crime) to appear and expand [17].

Homeless Link, a charity dedicated to providing physical examinations to the homeless, has presented the results of its research involving 2590 homeless people in 19 counties in England. It shows a high percentage of health problems among the target group of its social work, where 73% of people responding to the survey admitted physical health problems, and 80% were suffering from some form of mental illness or disorder. In terms of substance abuse, 39% of respondents said that they were abusing drugs other than alcohol (or were recovering from drug addiction), while only 27% of them were using alcohol or recovering from alcohol dependence [18].

It can be further stated that substance abuse may be both a cause and the result of homelessness [19]. The National Coalition for the Homeless estimates that approximately 38% of homeless people suffer from alcohol

dependence and 26% of homeless people are drug addicts. While older homeless people tend to be alcohol dependent, substance abuse is more prevalent among the younger people [15].

In this context, homeless young people can be characterized as those between 12 and 24 years of age with no possibility of finding stable housing and who are identified with the *street culture* value model. Alcohol and/or drug abuse is an indispensable part of the lifestyle for many young homeless people to mitigate everyday worries and stress, while also replacing other physiological needs (such as the need for sleep and food). Although drug use can be seen as an attempt to escape from reality, drugs ultimately only contribute to a worsening of existing problems [20]. In their selected research, the authors identified *marijuana* to be the dominant drug of choice among the young homeless, followed by *opiates* [21].

Research in the United Kingdom has also shown people in homeless shelters to be eight times more often affected by psychiatric disorders, and those sleeping on the street eleven times more often affected than the resident population. In contrast, research findings in Prague (examining the presence of mental illness and behavioral disorders among homeless people seeing general practitioners between January 1, 2005 and May 31, 2006) showed addiction to be the most significant issue among them (23%), followed by depression (19%), sleep disorders (17%), stress responses and adjustment disorders (16%), schizophrenia (8%), personality disorders (4%), anxiety disorders (2%) and other unspecified diseases and disorders (11%) [12].

A significant problem in addressing health problems is the reluctance of physicians to care for and treat the homeless. Another questionnaire survey conducted in Prague (between August and December 2005) concentrated on the homeless in low-threshold social services facilities. 900 men and women participated in the research, which produced the following findings concerning mental health:

- 57% of the men (420) and 45% of the women (72) responded that they were not suffering from any anxiety or depression.
- 37% of the men (275) and 49% of the women (77) responded that they suffered from a moderate level of anxiety or depression.
- 6% of the men (41) and 6% of the women (10) responded that they suffered from an extreme level of anxiety or depression.
- 12% of the men answered that they drank daily, while 20% were abstinent.
- 4% of the women answered that they drank daily, while 50% were abstinent. However, these figures should not be considered a relevant factor, due to the fear of no longer being provided social services in charitable facilities because of repeated consumption of alcohol.
- Nearly 20% of men and women said that they were abusing addictive substances other than alcohol and tobacco (predominately marijuana, followed by stimulants and opiates). The use of volatile substances such as toluene, considered low-cost and a drug for the poor, was likewise confirmed among a small number of people [22].

## Materials and methods

This study focuses on mental illnesses as a factor in the development and persistence of homelessness in today's society. The study aims to identify the presence and the different types of psychiatric disorders among the homeless, while seeking a correlation between homelessness and mental illnesses. The research section presents the results from a survey conducted at a low-threshold day center in Trenčín, where we were working with a target group of homeless people. In this context, we decided to analyze the scope and presence of mental health disorders through qualitative research from semi-structured interviews of twelve selected participants of different ages (19–55 years) comprising eight men and four women, while simultaneously using low-threshold social services available in the observation period from January 1 to October 1, 2017. The participants were selected to form a group comprising people who had expressed interest in long-term contact and cooperation. However, it not only included people who had been homeless for protracted periods, but also those who had managed to become independent and get themselves housing, but were still either using low-threshold center services regularly after work or returning in their leisure time. The survey respondents were composed of six participants benefiting from shelter-related social services and four participants who had managed to acquire their own housing. The remaining two participants were still living on the street. The average age of the selected participants was approximately 37 years. The assessment concentrated on establishing five subcategories, in which we examined the length of time they had been homeless, the presence and type of mental illness, the current state of treatment and interest among them in addressing their psychological problems, as well as how they related to their social environment.

## Results

When examining how long the participants had been homeless, the responses ranged from shorter to longer periods of time, although all answers primarily approached long-term homelessness. Participant 1 mentioned losing his home more than a year ago: *"... immediately after I left my foster family."* Participants 2 and 10 (both men) considered themselves to have been homeless on repeated occasions, with Participant 2 responding by saying: *"I have been on the street for thirteen months, but it wasn't the first time I had gotten myself there."* Participant 10 claimed that he was spending his second month on the street and had been homeless once before. Participant 3 was not able to state the amount of time he had been living on the street: *"I cannot fairly say how long I have been homeless."* Participants 4 and 7 (both women) told us that they had never had their own housing. Participant 4 told us that she had not had her own home since her husband died 17 years ago, and Participant 7 since she divorced her husband ten

years ago. The longer time frame is also indicative of the following participants. Participant 5 mentioned having been on the street for two years before he came to a shelter, remarking: *"... it took three months there before I was living on my own."* Participant 8 said: *"... it will be almost three years... all the time living in a caravan parked along the Váh River."* Participant 9 commented on having been on the streets for about four and a half years: *"... I went through a lot in that time and lived anyway I could."* A similar sentiment was expressed by Participant 12, who said: *"On the street I lived five long years; hardly anyone can imagine what that's like."* Participant 4 pointed out that *"... I've been living with my father in a shelter for four years"*. Meanwhile, Participant 11 had been homeless for a shorter time: *"I am fortunate to have been living on the street only a month; now I am sharing an apartment with a friend."*

In addition, we were interested in the survey participants' psychological health and mental well-being. Only Participant 4 mentioned being in relatively good health with no psychological discomfort. Participant 11 claimed that just recently she had been depressed: *"... when I had no idea what was going to happen. Fortunately, everything turned out well."* However, a combination of several psychiatric disorders was encountered. Participant 1 mentioned not feeling well mentally: *"I have schizophrenia and get depressed... I'm tired of my life and I've attempted to kill myself twice... but at least alcohol and drugs give me satisfaction."* Similar thoughts were expressed by Participant 3: *"I have schizophrenia and am being treated in [Veľké] Zálužie for alcohol dependence."* Participant 12: *"I am certified as severely disabled with epilepsy and mental health problems."* Participant 9: *"I am suffering from depression, have attempted suicide a few times and have overdosed on drugs."* Signs of severe opiate addiction were evident in Participant 2 who claimed to have been once addicted to heroin: *"... but now I've switched to legal Suboxon."* Participant 8 commented about having been treated for alcohol dependence when he was younger. Participant 5 did not wish to specify her psychological problems, saying that she appreciated the approach her mother (a pharmacist) had taken and was starting to tackle these issues under her scrutiny. On the other hand, Participant 6 openly confessed his psychological problems, stating he had schizophrenia. Participant 7 was aware of her poor mental health, saying: *"I have psychological problems, I've reached the absolute bottom... this is not the life I used to lead... I'm unhappy with my life."* A similar comment was made by Participant 10: *"Everything's got me depressed, I'm unhappy about how I live... I don't know how to solve all the problems I have."*

The next question we were interested in asking was how the participants approached the treatment of their mental illnesses. In relation to the previous findings, only Participants 4 and 11 needed no medical attention. Participant 5 was the only respondent to confirm regular contact with a physician, saying she was seeing a doctor regularly. Participant 6 mentioned about going to a doctor every month for injections and regularly being prescribed medicines by her. Participant 12 described his own experiences: *"It's tough to take care of your health unless you have a home... it's been a long time since I was ever treated for anything and I know I'm gambling with my life,*

*but it's impossible otherwise.*" He has since managed to get social housing and is seeing a doctor regularly. In several cases, however, participants talked about refusing to seek medical assistance and then of either having abruptly ended treatment themselves or the physicians treating them ended it. Participant 1 did not trust his physician, justifying his suspicions by saying: *"My doctor does not understand me, shows no interest in helping me...and I need to talk to someone and he's just not concerned... so I left him."* Participant 3 found himself in a similar situation, stating: *"I had an argument with my doctor and refused to take my words back... and so no one knows anything and no one knows what I need to live."* Participant 2's physician ended his treatment after she discovered him using heroin while he was being treated: *"That was why she threw me out of her office... now I have to deal with how to get my benefits."* Participant 7 reflected on her own adverse mental state while she was hospitalized, but she subsequently refused the therapy they offered, claiming: *"I left there at my own request... I simply won't go there."* Neither Participant 9 (*"When I feel it's about me, I'll get the drugs anyhow."*) nor Participant 10 (*"There's so much the doctors should be doing with me... somehow I'm getting by."*) are seeing a physician regularly. Participant 8 is aware that, even though he was previously treated for alcohol dependence, he has no feelings about it at present, stating: *"I have no need to be healed, I know I have to be careful."*

Following up on their treatment status, we were also interested in whether the participants were still concerned about addressing the psychological problems of whose presence they were aware. Participant 3 unequivocally rejected any further therapy: *"I'm not getting any more treatment, I don't need to be ordered around."* Participant 2 expressed his own lack of interest in abstaining from addictive substances, justifying it by saying: *"I don't want to give up drugs."* Absolute resignation also accompanied Participant 1's comment: *"I feel alone, abandoned... why I have such a life... it doesn't matter to me even if I die."* Participant 9 expressed no concern about his health or the need to pull himself together: *"It's all the same to me; my life's been stolen."* Participant 7 was tackling her psychological problems with other addictive substances, commenting that alcohol and drugs calm her down. Participant 10 saw drugs as the answer to her fatigue and mental exhaustion. Participant 5 presented an interesting view, stressing the importance of social support: *"My mother helped me very much; without her I wouldn't have begun to look at my problems."* Given his health, Participant 6 considered the therapy model to be reasonable, although he mentioned that the drugs made him feel strange: *"I'm always sleeping, never want to eat anything... nothing else interests me."* Participant 12 saw her health improve when she was given access to housing: *"I feel better when I'm under supervision and with the drugs, too."*

The final issue we discussed was the relationship between the participants and their social environment. In the vast majority of cases, either indifference to the social environment or a negative attitude was encountered. Participant 1 mentioned about how the social environment turned him into someone else, *"I don't know if I could*

*ever have a normal life again, there's nowhere I could go".* Participant 2 remarked: *"The whole world is corrupt, I'm against this society and I don't acknowledge it."* A negative attitude toward the social environment was also expressed by Participant 3, who claimed: *"Everyone believes homeless people to be antisocial, and they don't want anything to do with them... but they'd be singing a different tune if they ever tried living on the street."* This view was also affirmed by Participant 12, saying, *"it's a pity, but there's evil and envy everywhere and the homeless have it especially tough".* Participant 8 also expressed a negative attitude toward the social environment, claiming: *"Everybody's always criticizing me for being homeless; I'd rather go somewhere far away because everyone here's against me."* Participants 6 and 7 had no interest in changing how they interacted with the social environment. Participant 6 remarked: *"I'm not interested in anybody, except my aunt, and when my mother calls or comes to see me."* Participant 7 said: *"I just want to be with my friends whom I need to live, and I don't want anyone else, no one else interests me."* Negative thinking could also be observed in Participant 9: *"I hate people; people are the cause of all the evil in the world."* Meanwhile, Participant 10 asked what he had to look forward to in life. *"Everybody leave me alone! I go to work and get nothing from it; practically everything has been taken away from me by the authorities... I'm tired of this life, of everything."* On the other hand, Participant 4 had a different opinion: *"Whoever behaves decently I can also behave decently to."* This was a view shared by Participant 5: *"I've met people who can be very evil and would even hurt those not guilty of anything. Therefore, I try to be good to everyone and get along with everybody. It's not the fault of everyone on the street that they got there."* Participant 11 did not blame the social environment for having become homeless, commenting: *"I did not see myself homeless; it was simply a crisis situation... and anybody can find themselves in such a situation, so let's not condemn anyone."*

---

## Discussion

A direct in-field qualitative survey was conducted at a low-threshold day center, where we worked with a target group of homeless people. The common feature in the survey was that the social services of a low-threshold day center were being used. In terms of how long the participants in the survey had been homeless, several different intervals were found, ranging from short-term (several months) to a continuing long-term period, up to lifelong homelessness (for 17 to 10 years). However, we mainly encountered long-term homelessness. Given that not all the participants disclosed how persistently they had been homeless, the average duration of homelessness was determined to be approximately 48 months (four years). Statements made in semi-structured interviews by the selected participants suggest psychological disorders that influence their mental health and well-being to a significant degree. It can be said that depression, anxiety, schizophrenia, suicidal tendencies and various kinds of dependencies were encountered. In most cases, we were able to see a single or multiple, interconnected psychiatric disorder.

Significant differences existed among the participants in terms of how these psychological disorders were being treated. Less than half of the surveyed respondents were in treatment (including those participants with no psychological problems evident) and were in regular contact with their physicians. However, in a great majority of cases the treatment offered to them had been interrupted (or rejected) by the participants, who felt misunderstood and were usually already relying on themselves. Several participants expressed a fear of doctors, not wanting to renounce existing dependencies on the addictive substances that had formed an important part of their lives (as a strategy for surviving on the street). Despite statements from some of the participants about *inappropriate* access to psychiatrists, such a point of view cannot be taken objectively because, from the perspective of the physicians, only one had discontinued treatment for someone who, even after substitute treatment for heroin dependence, was identified as having other addictive drugs present in contravention of the prescribed treatment.

In relation to any interest in overcoming their mental illnesses, the participants were aware of their psychological difficulties and the risks thereof (together with their consequences). In this context, the participants in treatment appreciated the significance of medical assistance. But on the other hand, there were many cases of refusal to have their problems solved professionally and of the application of an *alternative solution* comprising the consumption of various addictive substances, although it would only continuously worsen their mental state. It is important to note that such indifference and apathy can also be encountered among the participants toward both their own lives and any future prospects. The stance taken toward the social environment was accompanied by either a particularly negative attitude or indifference. What is most significant from the perspective of the homeless themselves appears to be concepts of injustice and poor governance in society, which thinks little about the needs of ordinary people. These concepts were likewise accompanied by an awareness of the presence of serious societal problems, including negative perceptions of homelessness by the majority society, whereas distorted view of the issue is common. The overwhelming majority of opinions show pessimism as a consequence of failure to overcome their own problems, while the continuance of their various mental illnesses creates a significant barrier limiting the social integration of these people (who live on the street or exclusively use social services in a shelter).

The research results indicate treatment of mental illnesses to be more effective (including providing more incentive to live) in those people who have their own housing (by virtue of a home with all the attributes related thereto). Under these circumstances, it is possible to agree with theoretical concepts describing both the inability to ensure permanent housing and untreated mental illnesses as expressions of an overall deterioration of health. In addition, there were also visible signs in the persons concerned of indifference and no motivation to live. Specific forms of behavior they expressed against their social environment included aggression and brushes with the law. There are other determinants derived from

housing that affect the lives of people and how they behave toward their social environment. In the case of the homeless, we can talk about a deep form of social exclusion among the individuals surveyed, such as that indicated by Fitzpatrick et al. [23], appealing to the interconnection between multiple dimensions of social exclusion and multiple social exclusion.

## Conclusion

Homelessness is a complex problem whose origin, course and duration is caused by several factors, not excepting health. Psychiatric disorders play an important role in this connection because many homeless people are suffering from one or more mental illnesses and possibly substance abuse. In this context, psychiatric disorders may be the primary factor behind homelessness, although they may also be secondary to homelessness. Thus, the absence of permanent housing is, to a significant degree, a sign of the inability to adequately tackle psychological problems, which also limits the person's options to overcoming homelessness, together with possible reintegration into society.

## Conflict of interests

The author has no conflict of interests to disclose.

## REFERENCES

- [1] Horváth P. Sociálny štát. In: Bočáková O, Špačková A (Eds). *Aktívne a zdravé starnutie – dôstojný život seniorov v 21. storočí*. Zborník, Nemšová 23–24 Január, 2013. Trnava: Fakulta sociálnych vied UCM v Trnave; 2013, pp. 17–30.
- [2] Amore K, Baker M, Howden-Chapman P. The ETHOS definition and classification of homelessness: an analysis. *European Journal of Homelessness* 2011;5(2):19–37.
- [3] Lindovská E. Homelessness coping strategies from housing ready and housing first perspectives. *European Journal of Homelessness* 2014;8(1):97–115.
- [4] Kolocek M. The human right to housing in the 27 member states of the European Union. *European Journal of Homelessness* 2013;7(1):135–54.
- [5] Walsh T. A right to inclusion? Homelessness, human rights and social exclusion. *Australian Journal of Human Rights* 2006;12(1):185–204.
- [6] Habánik T. Dimensions of poverty and homelessness in the European Union. In: Bočáková O, Habánik T, Kubičková D. (Eds). *Comprehensive view of the issue social services and the social-political significance of their support*. Gdansk: Research Institute for European Policy; 2017, pp. 71–103.
- [7] Shinn M. Homelessness, poverty and social exclusion in the United States and Europe. *European Journal of Homelessness* 2010;4(1):19–44.

- [8] Baggett TP, O'Connell JJ, Singer DE, Rigotti NA. The unmet health care needs of homeless adults: a national study. *American Journal of Public Health* 2010;100(7):1326–33.
- [9] Schanzer B, Dominiguez B, Shrout PE, Caton CLM. Homelessness, health status, and health care use. *American Journal of Public Health* 2007;97(3):464–9.
- [10] The PLoS Medicine Editors. Homelessness is not just a housing problem. *PloS Med* 2008;5(12):e1000003. <https://doi.org/10.1371/journal.pmed.1000003>
- [11] Bočáková O. Zdravotnícka politika ako súčasť sociálnej politiky. In: Sborník z konferencie Aktuálne otázky politiky: súbor vedeckých prác. Trenčín: TnUAD; 2014, pp. 5–12.
- [12] Šupková D. Zdravotní péče o bezdomovce v ČR. Praha: Grada Publishing; 2007.
- [13] Funk M, Drew N, Knapp M. Mental health, poverty and development. *Journal of Public Mental Health* 2012;11(4):166–85.
- [14] Bartošovič I. Some aspects of the health status of homeless people. *Clinical Social Work and Health Intervention* 2016;7(1):39–47.
- [15] Philipps K. Homelessness: causes, culture and community development as a solution. Paper 88; 2012. [online] [cit. 2017-09-18]. Available from: [http://digitalcommons.salve.edu/cgi/viewcontent.cgi?article=1088&context=pell\\_theses](http://digitalcommons.salve.edu/cgi/viewcontent.cgi?article=1088&context=pell_theses)
- [16] Keogh C, O'Brien KK, Hoban A, O'Carroll A, Fahey T. Health and use of health services of people who are homeless and at risk of homelessness who receive free primary health care in Dublin. *BMC Health Services Research* 2015;15:58. Doi 10.1186/s12913-015-0716-4.
- [17] The Shaw Mind Foundation. Mental health in the homeless; 2016. [online] [cit. 2017-10-04]. Available at: <http://shawmindfoundation.org/wp-content/uploads/2016/12/Shaw-Mind-Homelessness.pdf>
- [18] Homeless Link. The unhealthy state of homelessness. Health audit results; 2014. [online] [cit. 2017-09-19]. Available at: [https://www.homeless.org.uk/sites/default/files/site-attachments/The unhealthy state of homelessness FINAL.pdf](https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf)
- [19] Dvořáčková D, Bešeňová R, Kajanová A, Bergougui B. Health and social aspects of homelessness. *Kontakt* 2016;18(3):e179–e83.
- [20] Brabcová I, Vacková J. Koncepce deseti sociálních determinant zdraví. *Kontakt* 2013; XV(4):406–12.
- [21] Gomez R, Thompson SJ, Barczyk AN. Factors associated with substance use among homeless young adults. Substance abuse: official publication of the Association for Medical Education and Research in Substance Abuse 2010;31(1):24–34.
- [22] Barták M. Bezdomovství v ČR: Zdravotní stav bezdomovců a jeho determinanty. Ústí nad Labem: Univerzita J. E. Purkyně v Ústí nad Labem; 2009.
- [23] Fitzpatrick S, Bramley G, Johnsen S. Multiple exclusion homelessness across the UK: an overview of key findings; 2012. [online] [cit. 2017-09-14]. Available from: [https://www.hw.ac.uk/schools/doc/MEH\\_Briefing\\_No\\_1\\_2012.pdf](https://www.hw.ac.uk/schools/doc/MEH_Briefing_No_1_2012.pdf)